

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0032789 Facility Name: Sharon Healthcare Elms Address: 3611 N Rochelle Number City Zip Code County: Peoria Telephone Number: 309-685-4412 Fax # 309-685-4480 HFS ID Number: Date of Initial License for Current Owners: 8/15/87 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership Corporation X "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Anca Oviedo Telephone Number: 847-441-8200 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment. Officer or Administrator of Provider (Signed) (Type or Print Name) Anca Oviedo (Title) CFO Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Sharon Healthcare Elms

0032789 Report Period Beginning: 1/1/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,017			4,017	8
9	SNF/PED					9
10	ICF	26,744	871	137	27,752	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,761	871	137	31,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.81%

D. How many bed-hold days during this year were paid by the Department? 17 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO X

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO X

I. On what date did you start providing long term care at this location? Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978? YES X Date 8/15/87 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 98 and days of care provided 4,017

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL X MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES X NO

Tax Year: 12/31/11 Fiscal Year: 12/31/11 * All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	167,039	19,716	7,116	193,871		193,871		193,871			1
2	Food Purchase		189,358		189,358		189,358	772	190,130			2
3	Housekeeping	136,106		21,860	157,966		157,966		157,966			3
4	Laundry	90,328	33,095		123,423		123,423		123,423			4
5	Heat and Other Utilities			108,831	108,831		108,831	750	109,581			5
6	Maintenance	46,199		87,624	133,823		133,823	(2,662)	131,161			6
7	Other (specify):*											7
8	TOTAL General Services	439,672	242,169	225,431	907,272		907,272	(1,140)	906,132			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,425,445	119,896	20,453	1,565,794		1,565,794		1,565,794			10
10a	Therapy											10a
11	Activities	53,922	3,308	2,608	59,838		59,838		59,838			11
12	Social Services	117,407		11,106	128,513		128,513		128,513			12
13	CNA Training											13
14	Program Transportation			10,682	10,682		10,682	(10,682)				14
15	Other (specify):* Restorative	77,271			77,271		77,271		77,271			15
16	TOTAL Health Care and Programs	1,674,045	123,204	59,249	1,856,498		1,856,498	(10,682)	1,845,816			16
	C. General Administration											
17	Administrative	209,495		150,000	359,495		359,495	24,011	383,506			17
18	Directors Fees											18
19	Professional Services			38,692	38,692		38,692	832	39,524			19
20	Dues, Fees, Subscriptions & Promotions			8,928	8,928		8,928	(710)	8,218			20
21	Clerical & General Office Expenses	452,515		166,017	618,532		618,532	(128,197)	490,335			21
22	Employee Benefits & Payroll Taxes			429,780	429,780		429,780	1,952	431,732			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,030	2,030		2,030		2,030			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,445	61,445		61,445	93	61,538			26
27	Other (specify):*											27
28	TOTAL General Administration	662,010		856,892	1,518,902		1,518,902	(102,019)	1,416,883			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,775,727	365,373	1,141,572	4,282,672		4,282,672	(113,841)	4,168,831			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			43,251	43,251		43,251	82,286	125,537			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			974	974		974	59,477	60,451			32
33	Real Estate Taxes			51,131	51,131		51,131	3,848	54,979			33
34	Rent-Facility & Grounds			105,222	105,222		105,222	(99,185)	6,037			34
35	Rent-Equipment & Vehicles			21,656	21,656		21,656		21,656			35
36	Other (specify):*											36
37	TOTAL Ownership			222,234	222,234		222,234	46,426	268,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,118	519,731	524,849		524,849		524,849			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,118	573,386	578,504		578,504		578,504			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,775,727	370,491	1,937,192	5,083,410		5,083,410	(67,415)	5,015,995			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,960	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	772	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(10,682)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,443)	21		19
20	Contributions	(2,587)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(118,167)	21		24
25	Fund Raising, Advertising and Promotional	(927)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,852)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,926)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	53,511		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 53,511		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (67,415)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Sharon Healthcare Elms

ID# 0032789

Report Period Beginning: 1/1/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Deferred Maintenance	\$ (3,852)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,852)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	\$	Peoria Forest Partnership	100.00%	\$ 832	\$ 832	15
16	V	20	Dues, Fees, Subs		Peoria Forest Partnership		209	209	16
17	V	30	Depreciation		Peoria Forest Partnership		60,326	60,326	17
18	V	32	Interest		Peoria Forest Partnership		59,477	59,477	18
19	V	33	Real Estate Tax		Peoria Forest Partnership		1,823	1,823	19
20	V	34	Rent	90,585	Peoria Forest Partnership			(90,585)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 90,585			\$ 122,667	\$ * 32,082	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$	Redwood Management	100.00%	\$	\$	15
16	V								16
17	V								17
18	V								18
19	V	17	Salary-J. Shlofrock		Redwood Management	100.00%	18,056	18,056	19
20	V	22	Payroll Taxes-JS		Redwood Management	100.00%	1,483	1,483	20
21	V								21
22	V								22
23	V								23
24	V	17	Salary-S. Aron		Redwood Management	100.00%	5,955	5,955	24
25	V	22	Payroll Taxes-SA		Redwood Management	100.00%	469	469	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V	17	Management Fees		Redwood Management	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 25,963	\$ * 25,963	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Barton Management	100.00%	\$ 750	\$ 750	15
16	V	6	Repairs and Maint		Barton Management	100.00%	1,190	1,190	16
17	V	20	Dues,Licenses,Fees		Barton Management	100.00%	8	8	17
18	V	26	Emp. Ben. Gen. Admin		Barton Management	100.00%	93	93	18
19	V	33	Real Estate Taxes		Barton Management	100.00%	2,025	2,025	19
20	V	34	Rent Office Space		Barton Management	100.00%	5,800	5,800	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	Rent	14,400	Barton Management	100.00%		(14,400)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 14,400			\$ 9,866	\$ * (4,534)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Shlofrock	Owner	Administrative	15.30	See Attached	6.5	0.16	Alloc Rdwd	\$ 18,056		1
2	Anca Zota-Oviedo	Shareholder	Administrative	1.00	See Attached	3	0.08	Alloc Salary	24,509		2
3	Elisa Shlofrock-Zusman	Owner	Administrative	12.08	See Attached			Alloc Salary			3
4											4
5	Rick Duros	Owner	Administrative	7.91	See Attached	5	0.13	Alloc Salary	54,005		5
6	Stan Aron	Owner	Administrative	15.28	See Attached	3.5	5.00	Alloc Rdwd	5,955		6
7	Gary Weintraub	Owner	Legal	9.95	See Attached	4	0.12	Alloc Salary	49,705		7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 152,230		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sharon Healthcare Elms # 0032789 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Sharon Healthcare Elms # 0032789 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Peoria Forest Partnership
Street Address 465 Central Ave, Suite 100
City / State / Zip Code Northfield, IL 60093
Phone Number (847-441-8200
Fax Number (847-441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Professional Fees	Bed Size	585	4	\$ 4,965	\$	98	\$ 832	1
2	20	Dues, Fees, Subs	Bed Size	585	4	1,250		98	209	2
3	30	Depreciation	Bed Size	585	4	360,112		98	60,326	3
4	32	Interest	Bed Size	585	4	355,040		98	59,477	4
5	33	Real Estate Tax	Bed Size	585	4	10,881		98	1,823	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 732,248	\$		\$ 122,667	25

Facility Name & ID Number Sharon Healthcare Elms # 0032789 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Redwood Management
Street Address 465 Central Ave, Suite 100
City / State / Zip Code Northfield, IL 60093
Phone Number (847-441-8200
Fax Number (847-441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4	17	Salary-J. Shlofrock	Avg Hours Worked	36	6	100,000	100,000	7	18,056	4
5	27	Payroll Taxes-JS	Avg Hours Worked	36	6	8,216		7	1,483	5
6										6
7	17	Salary-S. Aron	Avg Hours Worked	39	5	66,360	66,360	4	5,955	7
8	27	Payroll Taxes-SA	Avg Hours Worked	39	5	5,223		4	469	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 179,799	\$ 166,360		\$ 25,963	25

Facility Name & ID Number Sharon Healthcare Elms # 0032789 Report Period Beginning: 1/1/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Barton Management, Inc.
Street Address 465 Central Ave, Suite 100
City / State / Zip Code Northfield, IL 60093
Phone Number (847-441-8200
Fax Number (847-441-0800

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Available Days	555,055	9	\$ 11,639	\$	35,770	\$ 750	1
2	6	Repairs ans Maint	Available Days	555,055	9	18,458		35,770	1,190	2
3	20	Dues,Licenses,Fees	Available Days	555,055	9	127		35,770	8	3
4	27	Emp.Ben.Gen.Admin.	Available Days	555,055	9	1,451		35,770	94	4
5	33	Real Estate Taxes	Available Days	555,055	9	31,421		35,770	2,025	5
6	34	Rent Office Space	Available Days	555,055	9	90,008		35,770	5,800	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 153,104	\$		\$ 9,867	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10	Allocated from Peoria Forest	X										59,477	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ 59,477	14
15	TOTALS (line 9+line14)						\$					\$ 59,477	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																						
1. Real Estate Tax accrual used on 2010 report.			\$	51,234	1																																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	54,274	2																																			
3. Under or (over) accrual (line 2 minus line 1).			\$	3,040	3																																			
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	51,939	4																																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6																																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	54,979	7																																			
Real Estate Tax History:																																								
Real Estate Tax Bill for Calendar Year:		<table><tr><td>2006</td><td>44,371</td><td>8</td></tr><tr><td>2007</td><td>44,379</td><td>9</td></tr><tr><td>2008</td><td>45,566</td><td>10</td></tr><tr><td>2009</td><td>48,657</td><td>11</td></tr><tr><td>2010</td><td>54,121</td><td>12</td></tr></table>	2006	44,371	8	2007	44,379	9	2008	45,566	10	2009	48,657	11	2010	54,121	12	<table><tr><td></td><td colspan="2">FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2010</td><td>\$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr></table>				FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2010	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2006	44,371	8																																						
2007	44,379	9																																						
2008	45,566	10																																						
2009	48,657	11																																						
2010	54,121	12																																						
	FOR BHF USE ONLY																																							
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13																																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																																					
15	LESS REFUND FROM LINE 6	\$	15																																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Sharon Healthcare Elms</u>	COUNTY	<u>Peoria</u>
FACILITY IDPH LICENSE NUMBER	<u>0032789</u>		
CONTACT PERSON REGARDING THIS REPORT	<u></u>		
TELEPHONE	<u>847-441-8200</u>	FAX #:	<u>847-441-0800</u>

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

PLEASE NOTE: *Payment information from the Internet* or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372

B. General Construction Type: Exterior Brick Frame

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Sharon Healthcare Willows - Facility - 219 Beds

Sharon Healthcare Woods - Facility - 152 Beds

Sharon Healthcare Pines - Facility - 116 Beds

Peoria Forest Partnership

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 107,214	1
2	Allocation-Peoria Forest			6,024	2
3	TOTALS			\$ 113,238	3

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1987		5,207	165	20		(165)	3,984
10	Various		1988		4,581	124	20		(124)	3,584
11	Various		1989		1,877	60	20		(60)	1,333
12	Various		1990		6,666	134	20		(134)	5,321
13	Various		1991		23,422	713	20	1,171	458	15,623
14	Various		1992		19,136	575	20	957	382	12,153
15	Various		1994		9,731	250	20	487	237	4,326
16	Various		1995		2,723	69	20	136	67	1,141
17	Various		1996		4,103	106	20	206	100	1,639
18	Various		1997		19,387	497	20	970	473	7,115
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		1991		\$ 1,862,634	\$	35	\$ 53,218	\$ 53,218	\$	4
5			1991		39,368		31.5	1,250	1,250		5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68	Related Party Allocations(Page12-Rep & Page12ARep)	1,902,001	60,326		60,326		1,238,324	68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,998,834	\$ 63,019		\$ 64,253	\$ 1,234	\$ 1,294,543	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,998,834	\$ 63,019		\$ 64,253	\$ 1,234	\$ 1,294,543	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	1,843	2
3	Lawn Repair	1998	625	16	20	31	15	218	3
4	Water Softener	1998	1,700	44	20	85	41	592	4
5	Phone Shelf	1998	207		20	10	10	71	5
6	Rooftop Unit	1998	1,472	38	20	74	36	508	6
7	Amer II Minuteman	1998	272	7	20	14	7	94	7
8	Patio Ramp	1998	538	14	20	27	13	184	8
9	Roofing	1998	3,187	82	20	159	77	1,080	9
10	Drapes	1998	5,805	149	20	290	141	1,942	10
11	Heat Condenser	1999	1,203	31	20	60	29	396	11
12	Windows	1999	81	2	20	4	2	27	12
13	Garage Door	1999	142	4	20	7	3	47	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	1,219	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	847	15
16	Windows	1999	481	12	20	24	12	157	16
17	Concrete Parking Lot	1999	969	25	20	48	23	302	17
18	Roof	1999	996	26	20	50	24	311	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	615	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	494	20
21	Renovation Design	2000	2,561	66	20	128	62	759	21
22	Renovation Design	2000	1,950	50	20	98	48	569	22
23	Garbage Disposal	2000	791	20	20	40	20	229	23
24	Water Heater	2000	345	9	20	17	8	100	24
25	Parking Spaces	2000	89	2	20	4	2	25	25
26	Parking Spaces	2000	3,720	95	20	186	91	1,068	26
27	Drapery	2000	5,588	143	20	279	136	1,594	27
28	Nurse Call Station	2000	3,544	91	20	177	86	1,011	28
29	Renovation Project	2000	398	10	20	20	10	112	29
30	Electrical Work	2001	1,427	37	20	71	34	398	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	6,986	31
32	Exit Door	2001	2,391	61	20	120	59	661	32
33	Renovation Design	2001	2,864	73	20	143	70	792	33
34	TOTAL (lines 1 thru 33)		\$ 2,082,481	\$ 65,158		\$ 68,434	\$ 3,276	\$ 1,319,794	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,082,481	\$ 65,158		\$ 68,434	\$ 3,276	\$ 1,319,794	1
2	Garage	2001	965	25	20	48	23	267	2
3	Drapery	2001	6,320	162	20	316	154	1,722	3
4	Install Drapery	2001	662	17	20	33	16	181	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	332	5
6	Gas Water Heater	2001	2,481	64	20	124	60	665	6
7	Compact Water Booster	2001	1,247	32	20	62	30	335	7
8	Drapery	2001	1,622	42	20	81	39	435	8
9	Install Roof	2001	4,357	112	20	218	106	1,168	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	257	10
11	Water Heater	2001	4,496	115	20	225	110	1,186	11
12	Replace Shingles	2001	923	24	20	46	22	244	12
13	Replace Refrig System	2001	1,092	28	20	55	27	286	13
14	Replace Shingles	2001	1,221	31	20	61	30	320	14
15	Flooring	2001	90	2	20	5	3	23	15
16	Parking Posts	2002	281	7	20	14	7	70	16
17	2 Exit Doors	2002	769	20	20	38	18	180	17
18	Roof Repair	2003	961	25	20	48	23	206	18
19	Dry Wall Repair	2003	1,672	43	20	84	41	352	19
20	Dining Room Roof-Roof Top	2003	1,943	50	20	97	47	409	20
21	Duct Work	2003	2,598	67	20	130	63	536	21
22	Flooring	2003	3,190	82	20	160	78	658	22
23	Roof	2004	4,760	119	20	238	119	937	23
24	Kitchen Floor	2004	994	25	20	50	25	189	24
25	Kitchen Floor	2004	1,133	28	20	57	29	214	25
26	Magnetic Door Alarms	2004	1,389	35	20	69	34	262	26
27	Rooftop Unit	2004	1,803	46	20	90	44	337	27
28	Wallpaper Renov Areas	2005	3,177	81	20	159	78	560	28
29	Lobby Rehab	2005	4,550	117	20	227	110	773	29
30	Renovation Front Doors	2005	1,327	34	20	66	32	225	30
31	Back Doors	2005	2,310	59	20	116	57	392	31
32	Locks for Lobby	2005	873	22	20	44	22	148	32
33	Bathroom Repairs	2005	979	25	20	49	24	164	33
34	TOTAL (lines 1 thru 33)		\$ 2,144,851	\$ 66,753		\$ 71,553	\$ 4,800	\$ 1,333,827	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,144,851	\$ 66,753		\$ 71,553	\$ 4,800	\$ 1,333,827	1
2	Lobby Rehab	2005	959	25	20	48	23	161	2
3	Remodeling Project-Frt Bldg	2005	729	19	20	36	17	122	3
4	Ceiling Tile Installation	2005	2,305	59	20	115	56	382	4
5	Ceiling Tile	2005	2,876	74	20	144	70	476	5
6	Front Lobby Renovation	2005	110	3	20	6	3	18	6
7	Carpet-Frnt of Bldg	2005	8,720	224	20	436	212	1,444	7
8	Carpet-Activity Room	2005	1,680	43	20	84	41	278	8
9	Ceiling Tile Replacement	2005	2,400	62	20	120	58	387	9
10	Dishroom Work	2005	796	20	20	40	20	128	10
11	Dining Room Ceiling Tile	2005	665	17	20	33	16	104	11
12	Dining Room Ceiling Tile	2005	604	15	20	30	15	95	12
13	Water Heater	2005	4,817	124	20	241	117	757	13
14	Ceiling Tiles	2005	604	15	20	30	15	94	14
15	Ceiling Tiles	2006	725	19	20	36	17	111	15
16	Condensing Unit	2006	1,040	27	20	52	25	143	16
17	Replace Ceilings	2006	6,769	174	20	338	164	904	17
18	Closet Wall Work	2006	890	23	20	45	22	119	18
19	Sidewalk	2006	7,888	202	20	394	192	1,053	19
20	Window Treatments	2006	1,504	39	20	75	36	198	20
21	Plumbing Services	2007	3,235	83	20	161	78	404	21
22	Picnic Pad	2007	2,123	54	20	106	52	265	22
23	Drapery, Valances	2007	600	42	20	30	(12)	226	23
24	Replace Water Heater	2007	1,184	136	20	59	(77)	1,116	24
25	Add Rock to Drive	2007	4,949	127	20	247	120	587	25
26	Water Booster	2007	215	15	20	11	(4)	81	26
27	Sidewalk	2007	1,298	150	20	65	(85)	1,223	27
28	RTU-Roof Top Unit	2007	444	31	20	22	(9)	167	28
29	Wall Pks/Emergency Lighting	2007	7,700	197	20	385	188	880	29
30	Cubicle Curtains	2007	5,848	150	20	292	142	669	30
31	Windows	2007	2,044	235	20	102	(133)	1,926	31
32	Kitchen Exhaust Duckwork	2007	2,218	57	20	111	54	249	32
33	Dining Room Flooring	2007	6,950	178	20	347	169	750	33
34	TOTAL (lines 1 thru 33)		\$ 2,229,740	\$ 69,392		\$ 75,794	\$ 6,402	\$ 1,349,344	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,229,740	\$ 69,392		\$ 75,794	\$ 6,402	\$ 1,349,344	1
2	Electrical Worl Alarm	2007	2,779	320	20	139	(181)	2,619	2
3	Alarm	2007	1,547	178	20	77	(101)	1,458	3
4	Landscaping Work	2007	2,050	142	20	103	(39)	772	4
5	Roof Top Units	2007	12,870	330	20	643	313	1,334	5
6	Generator Study	2007	1,776	46	20	89	43	184	6
7	Water Softener Maintenance	2007	3,750	96	20	187	91	389	7
8	Remodel Halls	2008	1,956	50	20	98	48	199	8
9	Nursing Station	2008	6,800	174	20	340	166	661	9
10	Cabinets	2008	3,190	184	20	159	(25)	2,914	10
11	Renovate Hallways	2008	2,368	61	20	118	57	225	11
12	Fence	2008	8,542	329	20	427	98	5,584	12
13	Landscaping Work	2008	718	28	20	36	8	470	13
14	Landscaping Work	2008	942	36	20	47	11	616	14
15	Landscaping Work	2008	735	28	20	37	9	480	15
16	Alarm System	2008	801	21	20	40	19	68	16
17	Borders	2008	1,361	35	20	68	33	112	17
18	New Walk	2008	1,268	33	20	63	30	102	18
19	Shower Room	2008	2,201	56	20	110	54	172	19
20	Shower Room	2008	1,633	42	20	82	40	127	20
21	Shower Room Door	2008	1,429	37	20	71	34	111	21
22	Dining Room Flooring	2007	37,289	956	20	1,864	908	3,944	22
23	Drywall Removal	2009	6,200	159	20	310	151	471	23
24	Roof Deck-Insulation	2009	23,682	607	20	1,184	577	1,747	24
25	Picnic Shelter Fence	2009	5,300	227	20	265	38	3,261	25
26	Generator	2009	84,443	2,165	20	4,222	2,057	6,228	26
27	Remodel Shower Room	2009	1,522	39	20	76	37	99	27
28	Exhaust Fan	2009	4,700		20	235	235	4,700	28
29	Parking Lot-Swale	2009	750	32	20	37	5	461	29
30	Regrade Trenches	2009	834	36	20	42	6	513	30
31	Vinyl Fence	2009	2,777	119	20	139	20	1,709	31
32	Concrete-Parking Lot	2009	14,238	609	20	712	103	8,760	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,470,191	\$ 76,567		\$ 87,814	\$ 11,247	\$ 1,399,834	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sharon Healthcare Elms

0032789

Report Period Beginning:

1/1/11

Ending:

12/31/11

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,470,191	\$ 76,567		\$ 87,814	\$ 11,247	\$ 1,399,834	1
2	Concrete-Patio,Walkway	2009	7,037	301	20	352	51	4,330	2
3	Shower Room-Remodel	2009	788	20	20	39	19	50	3
4	Regrade, Seed Around Shelter	2009	1,200	51	20	60	9	738	4
5	Tile-Downspouts	2009	1,356	58	20	68	10	834	5
6	Replace Cable Lighting	2009	1,202	31	20	60	29	73	6
7	Roof Top Unit w/ Gas Heat	2009	8,600	221	20	430	209	487	7
8	Roof Repair	2009	751	19	20	38	19	39	8
9	Park Bench Canopy	2008	7,488	431	20	374	(57)	6,841	9
10	Carpet	2010	1,122		20	56	56	1,122	10
11	Doors & Frames	2010	3,882	100	20	194	94	112	11
12	Repipe Water Lines	2010	3,023	78	20	151	73	81	12
13	Repipe Water Heater	2011	5,356	75	20	268	193	75	13
14	New Roof	2011	25,605	356	20	1,280	924	356	14
15	Roof Unit: Gas Heat	2011	9,450	71	20	472	401	71	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,547,051	\$ 78,379		\$ 91,656	\$ 13,277	\$ 1,415,043	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$69,358	\$6,062	\$13,342	\$7,280	10	\$64,718	71
72	Current Year Purchases	19,136	19,136	3,661	(15,475)	10	19,136	72
73	Fully Depreciated Assets	497,385		14,460	14,460	10	497,377	73
74								74
75	TOTALS	\$585,879	\$25,198	\$31,463	\$6,265		\$581,231	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 Chevy Van	2001	\$2,463	\$	\$	\$	5	\$2,463	76
77		2001 Dodge Van	2004	2,945				5	2,945	77
78		2008 Chevy Express	2009	10,244		2,049	2,049	5	10,244	78
79		Tractor	2009	1,844		369	369	5	1,844	79
80	TOTALS			\$17,496	\$	\$2,418	\$2,418		\$17,496	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,263,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$103,577	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$125,537	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$21,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,013,770	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Alloc-Barton Mgmt				2,025			5
6								6
7	TOTAL				\$2,025			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO

16. Rental Amount for movable equipment: \$21,656
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 110,557	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000)	1,916,146		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,358		6
7	Other Prepaid Expenses	11,899		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,068,960	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	645,049		15
16	Equipment, at Historical Cost	417,494		16
17	Accumulated Depreciation (book methods)	(589,563)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 472,980	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,541,940	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 199,621	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,000		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,646		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,994		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,939		32
33	Accrued Interest Payable	974		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,351,975		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,747,149	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Line of Credit	510,000		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 510,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,257,149	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 284,791	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,541,940	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 265,948	1
2	Restatements (describe):		2
3	State Replacement Tax	6,484	3
4	Accrued 401K Contribution	(948)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 271,484	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	14,757	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 14,757	17
	B. Transfers (Itemize):		
18	Treasury Stock	(1,450)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (1,450)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 284,791	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,097,884	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,097,884	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	283	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 283	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,098,167	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,518,902	31
32	Health Care	1,856,498	32
33	General Administration	907,272	33
	B. Capital Expense		
34	Ownership	222,234	34
	C. Ancillary Expense		
35	Special Cost Centers	524,849	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,083,410	40
41	Income before Income Taxes (line 30 minus line 40)**	14,757	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 14,757	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,008	2,160	\$ 64,854	\$ 30.03	1
2	Assistant Director of Nursing	1,960	2,088	49,388	23.65	2
3	Registered Nurses					3
4	Licensed Practical Nurses	23,591	25,343	637,201	25.14	4
5	CNAs & Orderlies	60,422	63,958	651,835	10.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,076	5,399	53,922	9.99	10
11	Social Service Workers	6,583	7,135	117,407	16.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,521	13,879	167,039	12.04	15
16	Dishwashers					16
17	Maintenance Workers	2,915	3,099	46,199	14.91	17
18	Housekeepers	12,674	13,928	136,106	9.77	18
19	Laundry	9,272	10,049	90,328	8.99	19
20	Administrator	2,080	2,200	81,349	36.98	20
21	Assistant Administrator					21
22	Other Administrative	936	936	128,146	136.91	22
23	Office Manager					23
24	Clerical	7,669	8,169	452,515	55.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,842	2,050	22,167	10.81	31
32	Other Health Care restorative	5,704	6,333	77,271	12.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	155,253	166,726	\$ 2,775,727 *	\$ 16.65	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	156	\$ 7,116	1-3	35
36	Medical Director	228	14,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	156	7,169	10-3	40
41	Occupational Therapy Consultant	130	6,327	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	104	5,157	10-3	43
44	Activity Consultant	52	2,608	11-3	44
45	Social Service Consultant	104	4,489	12-3	45
46	Other(specify)				46
47	Psychiatric Director	78	6,617	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,104	\$ 55,683		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Sherry Ford	Administrator	0	\$ 81,349
Rick Duros	Administrator	7.91%	54,005
Arnie Kanter	Administrator	0	49,632
Anca Zota-Oviedo	Administrator	1%	24,509
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 209,495
B. Administrative - Other			
Description			Amount
Redwood Management			\$ 150,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,000
C. Professional Services			
Vendor/Payee	Type		Amount
SEE ATTACHED SCHEDULE			\$ 38,692
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 38,692
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 68,969
Unemployment Compensation Insurance			37,094
FICA Taxes			179,743
Employee Health Insurance			102,674
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Retirement Plan Contribution			32,658
Employee Benefits			8,642
TOTAL (agree to Schedule V, line 22, col.8)			\$ 429,780
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			1,509
Health Care Worker Background Check (Indicate # of checks performed 148)			1,486
Patient Background Checks 127			1,270
License & Fees & Permits			3,300
Dues & Subscriptions			653
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,218
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			2,030
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 2,030

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Painting & Decorating	2004	\$ 98	4	\$ 16	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	2005	0	4	0	0	0						
3	Painting & Decorating	2006	1,444	4	481	481	241						
4	Painting & Decorating	2007	1,312	4	219	437	437	219					
5	Painting & Decorating	2008	188	4		31	63	63	31				
6	Painting & Decorating	2010	5,101	4				850	1,700	1,700	851		
7	Painting & Decorating	2011	1,561	4					260	520	520	261	
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 9,704		\$ 716	\$ 949	\$ 741	\$ 1,132	\$ 1,991	\$ 2,220	\$ 1,371	\$ 261	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes, only 'CNA's
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,371 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? N/A
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.